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The Ten Essential Shared Capabilities: Reflections on education in values-based practice: A qualitative study☆

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SUMMARY

Background: This paper presents the findings of a study exploring the impact of a values-based training initiative on the practice held by mental health workers. This work is set within the context of increasing attention on values of nurses and other health care workers as a response to national reports on care failure and negative media attention.
Objective: To examine written response feedback from participants on a national training programme for values-based practice (VBP) in order to examine an intention to change practice.
Design: A national evaluation using quantitative and qualitative methodologies was conducted to gather data on reflections and self-report impact of the Ten Essential Shared Capabilities' training programme.
Setting: The training was delivered in a range of hospital, community and third sector training programmes across eight regions in England.
Participants: The participants were predominantly nurses but all sectors in the mental health community including service users as co-facilitators and participants were represented.
Methods: This study presents the qualitative findings from a cross-sectional survey. Using NVIVO 10 software, data were analysed using the framework method of qualitative analysis.
Results: Four principal themes emerged from the data: 'Thinking differently', 'Changes to practice', 'Creating an effective learning environment and skills for practice development' and 'Increasing self-awareness'.
Conclusions: The quality and safety drive in the NHS has an emphasis on delivery of evidence-based practice. We conclude that an active focus on values-based practice merits equal attention and status.

Introduction

Standards of nursing practice and education in England are subjected to much external scrutiny. There are a number of critical reviews that focus on the mismatch between the values of the NHS (Department of Health (DH), 2013) and the practice and behaviour of nurses and those from other disciplines (HM Government, 2013). There have been large-scale reviews on mortality rates in hospital such as that conducted by the Chief Medical Officer (Keogh, 2013). Other reports also provide details of where care and support of nursing and other personnel have fallen well short of acceptable standards (Parliamentary and Health Service Ombudsman, 2011; Healthcare Commission, 2011). These reviews focus not only on nursing practice but also seek fundamental answers about the commitment of the NHS to patient safety (Berwick Report, 2013). A common element is the reference to 'values' and 'quality' in NHS provision.

The highest public concern has focused on the standard of care at the Mid-Staffordshire Hospital Trust in the Midlands of England. This led to a national enquiry led by Lord Francis, culminating in 290 recommendations for improvement in health care practice. In the recent response to the Francis enquiry, the Department of Health set out the commitment to the values in the NHS constitution (DH, 2013). Central to this is the understanding that patients are at the core of decision-making, not simply passive recipients of care or treatment. Specifically, the document sets out the value of 'respect and dignity' and 'compassion'. A further commitment to putting the interests of patients before those of any organisation or system was made (Department of Health, 2006).

This recent scrutiny of the NHS has led to a recognition of the need to reflect on current culture and practice in the NHS and the revisiting of the values that underpin practice. One direct initiative is the consultation by The Care Quality Commission on a new set of fundamental standards: the inviolable principles of safe, effective and compassionate care that must underpin all service delivery in the future.

Public declaration of a commitment to quality health care is further evidenced by the Chief Nursing Officer's articulation of the 6 Cs (compassion, courage, care (quality/safety), communication, commitment and competency) (Department of Health/Chief Nursing Officer, 2012), and the introduction of over two hundred care makers as ambassadors

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for the 6 Cs. This focus on quality and values is the result of a number of high-profile quality failings (Parliamentary and Health Ombudsman, 2011; HM Government, 2013).

Despite these recent high-profile cases and the responses at the national level, discussions on values in underpinning practice is not new. Values-based practice (VBP) is an approach to health care delivery seeking to compliment evidence-based practice (EBP) (Fulford, 2008). It is the utilisation of skills to promote balanced decision making in patient care, whilst also accounting for the complex web of differing value perspectives that lie behind the decision-making process.

In 2004, mental health services launched a specific national initiative on values and practice, called the 'Ten Essential Shared Capabilities' (DH, 2004). To support this policy guidance, a 'values-based' set of educational materials were developed by the Sainsbury Centre for Mental Health and the National Institute for Mental Health England (NIMHE).[1] Since the closure of the NIMHE, a team of Mental Health academics at Lincoln University maintained responsibility for the ongoing development of ESC-related resources (CCAWI/MHRED, 2009).[2]

The ESCs are a description of the core aspects of practice that support service user focused care and treatment in mental health. They set out a range of core values and capabilities that all staff working in mental health services should achieve as a minimum within their fundamental care delivery. They were developed with the assistance of mental health service users, carers and personnel. To support their introduction and to gain detailed understanding of their potential impact, an educational learning resource was piloted across England.

With specific reference to the issues outlined above, this paper reports on the evaluation of a national pilot of a values-based practice (VBP) education programme aimed at linking the values held by clinicians to their practice.

Initial quantitative data from the evaluation of the pilot study have been published elsewhere (Brabban et al., 2006). This current paper provides an in-depth analysis of the qualitative data relating to the experiences of the learners on the pilot of the national rollout of the programme.

The training initiative: development of the educational (ESC) resource pack

The resource pack, which consisted of a set of learning materials in both CD-ROM and paper format, was developed as part of an implementation plan on the core skills, values and knowledge needed to deliver service user-focused practice. The basis of VBP views 'values' not as philosophical constructs, but rather as a highly practical, behavioural endeavour with significant application in everyday practice. The aim of the programme was therefore to move beyond an acknowledgement of a statement of values, into understanding how values are manifest within nursing and other professional practices and identifying the challenges and opportunities that VBP presents.

Principles governing programme delivery

The ESC programme has an emphasis on self-reflection and group discussion around the practical application of values in practice. A key principle of the programme was promoting 'respect for difference of values'. The aims were to support and challenge participants to feel able to talk openly about their views about work, mental health and care delivery. Differences of opinion were considered a valuable resource when exploring the role of values in guiding personal approaches to practice.

The programme comprised the following five modules:

i) Introduction to the ESC
ii) Involving service users and carers
iii) Values-based practice
iv) Race equality and cultural capability and
v) Developing socially inclusive practice

Implementation

To identify the implementation sites, the Chief Executive of each NHS Mental Health Trust was contacted and invited to participate in the pilot programme.

This resulted in sixty sites from across eight regions in England offering to participate.

Following participation consent from the Trust Executive, a nominated lead from the region was identified to coordinate activities. Preparation events were planned and delivered by these regionally nominated leads.

The national programme manager and principal investigator (IMcG) attended planning events in each region and had ongoing contact with a representative of every site. Each site had flexibility on how to deliver the programme as long as the national manager was satisfied that they adhered to the national objectives.

Three options were available for the delivery of the programme:

1. Full face-to-face group sessions
2. Provision of the resources for self-directed study with subsequent group follow-up/discussion
3. Provision of the resources for self-directed study alone

The first of these three options was by far the most popular with very few opting for option three.

The programme was delivered over a period of three months.

Local training facilitators (service user trainers, university lecturers or organisational in-service training leads) were recruited to the pilot. Selection was based on their experience as competent facilitators.

Methods

This study presents the qualitative findings from a cross-sectional survey. A questionnaire was developed to measure the experiences and views of the participants. To achieve a high response rate, participants were asked to complete the paper questionnaire and return to the facilitator, who, in turn, posted the full batch to the principal investigator. Envelopes were coded numerically so that responses from individual sites could be identified. Individual consent was implied by virtue of completion of the questionnaire. Initial quantitative data from the evaluation of the pilot study have been published elsewhere (Brabban et al., 2006).

A total of sixty sites offered to participate in the training, but only thirty-seven sites provided any follow-up data in the form of questionnaire responses. Therefore, in this study, we consider the sampling frame to constitute all known trainees on the programme ($n = 579$) who were located in the thirty-seven training sites in England. The ESC programme feedback questionnaire contained multi-choice scales and the opportunity to provide free text responses. The research team received multi-choice questionnaire data from all 579 participants. The number of participants who provided qualitative written feedback totalled 385, equivalent to a sixty-six percent response rate for additional free text data. It is this qualitative data that forms the basis of this study.

Respondents were asked to provide basic demographic data but were not required to identify themselves. Questionnaires were coded

[1] The NIMHE was later disbanded and a new body, the National Mental Health Development Unit was launched in 2009. However, the NMHDU was also disbanded in March 2011.

[2] The Centre for Clinical Academic Workforce Innovation (CCAWI), a research centre at the University of Lincoln has now been re-established as the Mental Health Research, Education and Development (MHRED).

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on receipt and hard copies were stored in a locked filing cabinet in the office of the principal investigator.

All free text responses were entered into a word processing programme and analysed using NVivo (version 10). Qualitative data were analysed using the 'Framework' method of qualitative data analysis (Ritchie and Spencer, 1994) developed by the then Social and Community Planning Research (now the National Centre for Social Research), which involved the following five steps:

- Familiarisation with the material
- Identifying a thematic framework (and developing a coding frame)
- Indexing (applying codes to the data)
- Charting (on a spreadsheet, to allow analysis within and between themes using data from all the interviews)
- Mapping and interpretation

Results

A wide range of professions (occupational therapy, social work, housing, administration) were represented, as were students, service users and carers. However, the majority (forty-seven percent) were nurses, student nurses and nursing-related professionals.

Data from the free text responses were first coded via inductive reasoning using open codes and the text was analysed using both descriptive and interpretive approaches. Once the coding system was established, new data from each responder were compared to the codes already generated, using the constant comparison method.

The codes identified were then grouped according to themes emerging from the sets of coded data.

A number of themes emerged from the data and these are identified below.

The training programme appears to support participants by enabling them to improve their skills as values-based practitioners. The themes identified include the following:

Theme one: Thinking differently

The programme encourages practitioners to 'think differently' about their practice and engagement with their service users.

Responses included practitioner statements around broadening their range of thinking, thinking beyond their patients' immediate mental health needs in order to prepare them for the future and being able to place themselves more effectively within the mind-set of the service user. Respondents stated that they were now in a better position to recognise and value the skills of others within the team and learning from others, which should encourage improved partnership working. Many respondents felt that the programme helped them to understand and appreciate the current mismatch between values and practice.

> To think beyond their (service user) mental health needs. It made me think far more about how occupation, employment, relationships and environment can impact on mental health

Others realised that they did not know what they thought they knew. People who may have previously agreed with written value statements, making the assumption that their practice mirrored these, had the opportunity, through the programme, to re-evaluate whether their practice was in fact in harmony with their values.

> I like to think that I thought of the 10 ESCs before learning. However, after the completion of the programme, I realise that I did this very little. I now make these a priority and actively think of these when working

Many respondents stated that they realised that they had not placed the service user at the centre of the process and now felt more able to consider their practice from the perception of the service user. It was important to maintain a state of positivity, give hope and consider the service user as the customer.

Theme two: Changes to practice

The above examples link to the second theme, which encouraged practitioners to 'make changes to their practice' to more fully engage in values-based practice. Participants offered thoughts around the determination to reduce and challenge racism, observing behaviours of staff, acting more decisively if poor practices are observed and taking a more holistic attitude towards the initial assessment of service users. Improved partnership working was stated as an important aspect of the programme and this related to both service users and carers and working with other organisations. Many respondents stated that they did feel empowered by the programme to challenge problems within their services and felt that their motivation and confidence to change practice had increased.

> Throughout the training I've been able to identify ways in which staff attitudes impact on the care provided to people—it has helped to give me the enthusiasm to try and challenge issues within the nursing team, environment etc in order to improve patient care.

Respect for the differing values of others—a key feature of the programme, gave participants the freedom to challenge their own and others values and assumptions in practice. Respondents felt that they were helped to develop skills such as critical exploration and reflection.

> It increased my awareness of issues that are often mentioned in mental health, but frequently ignored. By asking practical questions and asking how I could change my practice/how this reflected on my team, it forced me to critically explore my attitudes and actions.

The learning resources encouraged reflection into cultural capabilities, awareness of cultural stereotypes and the promotion of inclusive practices.

Theme three: Creating an effective learning environment and skills for practice development

The programme encouraged participants, through facilitated group discussions, to openly explore the 10 ESCs and how good practice could be identified. Bringing 'real-life' experiences to the debate and learning from others was felt to enhance the learning experience.

New knowledge within the field through the provision of learning materials was felt to be a valuable aspect of the programme. Many participants expressed a confidence that the skills developed as a result of the programme would enable their practice to develop positively in the future.

> Thank you for giving me the opportunity to learn the ESCs in detail. This learning gave me a solid and structured framework for my professional capabilities. I would say that this has given me a new learning horizon

Although the participants reported high levels of enthusiasm by towards the end of the programme, many alluded to potential problems of implementing new approaches in the work place. Barriers such as personal time, and structural/organisational constraints were reported. The sense of frustration and lack of power that health workers feel in relation to organisational barriers was evident.

> Learning about recovery as an approach was refreshing and a challenge to the traditional ill health/medical model. As with a lot of the content of this programme found that the need for organisational

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change is essential to facilitate change and free thinking. Constraints placed on individuals seem to come through organisational processes and systems which can appear to contradict or stifle the development of some of the user based values.

Theme four: Increasing self-awareness

Participants expressed the view that engagement with the programme increased their self-awareness and appreciation of how their own attitudes and prejudices may impact on others and their practice.

There was evidence that the content of the programme, particularly the aspects relating to inequality, inspired participants to consider the potential impact of their own behaviour on other staff, clients and carers. Participants stated that they were able to revisit extant perspectives, sparking a re-engagement with their personal and professional responsibilities and consider whether their knowledge base was sufficient to meet the demands of the job.

> Throughout this project I have learnt a lot of things about my work. Things that I already know but which I did not consider important and I have come across lots of issues which I really need to increase my knowledge of thethe learning programme has made me more aware of the needs of clients and carers..... however, current time constraints and increased workloads mean I have not been able to put my new knowledge into practice as much as I would like to

As with the earlier discussions, although participants articulated their frustrations, many more appeared positive about their newly developed awareness, ability to think differently and a determination to be active in creating change.

For many participants, the exploration and examination of personal values set against service user experience created some incongruence. This incongruence is seen as a learning opportunity to promote positive challenge and positive action planning. The ESC programme is predicated on the principle of respect for the values of others. This key principle of mutual respect facilitated the opportunity for participants to challenge their own and others value assumptions and practice. This sense of re-evaluation and ongoing personal development was a significant feature of participants' responses.

The point of values-based practice initiatives such as the 10 ESCs is to support a repositioning of service user involvement and shared decision-making in their care.

The programme, through the themes generated by the qualitative data, appears to be successfully instilling a sustainable learning model, which may evolve into lifelong learning and improved partnership working, which is supported through the values-based philosophy.

Discussion

This research has highlighted many potential benefits of the provision of educational resources to support the implementation of VBP in the delivery of mental health care.

Given recent attention around the quality of care in the NHS and the subsequent formal responses by, for example, the introduction of the 6 Cs by the Chief Nursing Officer for England, it is legitimate to ask, what is behind this promotion of core 'values' and what public value statements mean to people who receive services? Without substance, declarations of values can be promoted like bland corporate mission statements, which have little resonance in the day-to-day practice of mental health nurses and therefore for all their good intentions have little or no impact (Di Battista et al., 2002).

This evaluation has provided evidence that, where supported, participation in educational programmes has the potential to contribute to greater understanding of patient-centred care based on core values and renewed enthusiasm and determination to implement these principles into practice. Values-based practice (VBP) is predicated on the belief that different perspectives should be respected. Respect for alternative points of view is seen as an opportunity to open dialogue and positively challenge and reflect on personal, societal and organisational values, attitudes and behaviours (Seedhouse, 2009).

Participants in this research discussed the importance of the development of their own clinical and professional skills in the implementation of VBP. Implicit in this is the drive for evidenced-based practice (EBP) as a highly desirable aspect of modern (mental) health services. However, it has been argued that the drive to consider EBP has minimised the role that values have in the delivery of care (Woodbridge and Fulford, 2004). It is rare that the evidence base for practice comes 'value free' (Fulford and Stanghellini, 2008).

This has been recognised elsewhere. Fulford et al. (2012) identified clinical and professional skills development, including EBP, as a key principle in the application of VBP. These include skills relating to the awareness and reasoning about values and evidence in practice.

It has been suggested (Edwards and Elwyn, 2009) that not only must practitioners think and reason about evidence, values and the everyday dilemmas of practice, they also need to consider their communication skills as a core tool for effective work in health care. In order to understand another person's position, their world view and their desires for treatment, practitioners must listen, observe and communicate effectively with people.

This study illustrates the importance of professional relationships and partnership working in the successful implementation of VBP. Health care is inextricably linked to relationships with others, including service users, carers and family members, other professionals in the multi-agency team, practitioners from the wider health and social care community, pressure groups and the general public. A diverse relationship inevitably involves a diversity of opinions. All these relationships are based on an understanding that a skilled, values-based practice clinician can acknowledge these differences, respect the difference of view and work towards a consensus. It is often uncertain whether a consensus will be reached and this reflects the reality of health care practice (Fulford et al., 2012).

Good clinical decisions in mental health are based on purposeful collaboration between the service user and the practitioner. The growth of service user involvement in practice, whilst not universal, has been remarkable (NICE, 2011). Within the wider health care field, the development of shared decision-making models (Coulter and Collins, 2011) is designed to develop processes where health care decisions or treatment options are made jointly between the service user and the clinician.

A feature of modern health care is the pace of work and the complex demands faced by a range of health care workers. The health needs of service users and their carers, the provision of information' clinical audit, multi-disciplinary/agency liaison, administration and organisational bureaucracy are some of the often competing demands on the time, focus and energy of a health care worker. Ensuring that 'patients come first' is a value, which is easily stated, yet in practice extremely challenging to deliver. Values-based practice programmes such as the ESC programme exist to help the workforce review the practice that is required behind the rhetoric. However, participants are always faced with the real challenge of addressing barriers to the implementation of new educational and clinical initiatives and good practice into the day-to-day clinical setting.

The skills of values-based practice (VBP) rests on the ability of practitioners to work in collaboration with people who use services in the search for balanced decision making. The process of working together is based on a number of key tenets designed to encourage health care workers to consider the importance and application of values in everyday health and social care practice and to purposefully act when competing values are in conflict. This issue of value-behaviour congruence is an important aspect of values-based practice (VBP) theory (Fulford, 2011). Values are only ever 'action-guiding', that is, having a stated value does not mean that practitioners will behave congruently with

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that value. VBP resources, such as the one reported here, seek a closer alliance between values and behaviour. It is through positive challenge and personal action orientated reflection that greater synergy between values and behaviour is achieved.

In summary, the drive for clinical quality through evidence-based practice must be delivered with a drive for values too. The quality and safety agenda requires some fundamental re-analysis of the role and practice of nurses in a multi-disciplinary/agency context. The data garnered from this study provides a significant insight into the issues that are pertinent to the individuals involved.

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